Robert Wood Johnson Foundation

Aligning Forces for Quality | Local Efforts to Transform American Health Care

AUGUST 2010

INTRODUCTION: THE QUALITY PROBLEM IN AMERICA

Few topics in public discourse create as passionate a response as the state of health care in America. For nearly a century, the health care debate has been buffeted by forces for broad sweeping change, incremental adjustment, and everything in between. Even as we embark on a new path toward health reform, consensus around how we as a nation should provide and pay for care has not been reached.

To some, the debate about health care in the 21st century may seem an all too familiar story. For years, the US has led industrialized nations in total and per capita health care spending.[1] The American public has been bombarded with stories of escalating health care costs, unbridled medical inflation, and the burdens that health spending carry for the country and its citizenry. Perhaps more troubling are the stories about the uninsured and underinsured – unconscionably high numbers of children, adults and families who walk a tightrope every day when it comes to their health and well-being.[2]

Yet with these familiar elements comes a new dimension to the debate: *the quality of health care in America*. Increasingly, doctors, hospitals, clinics and patients are looking at information about the health care they deliver and receive, and the results are alarming. No matter how you slice it, the evidence shows that we are not getting our money's worth when it comes to health care.

- *Americans have only about a 50-50 chance of getting the care they need, and those odds vary a lot depending on the patient's condition.*[3] For example, only one in three people with diabetes receive what they should for high-quality diabetes care; three out of four patients with breast cancer receive the tests, advice and services that evidence shows are essential for high-quality breast cancer care.

- *Getting health care can be a dangerous proposition.*[4] The US can take credit for clinical advancements that improve diagnostic and therapeutic care for countless individuals, yet systems to make sure that people get the right medications and the right treatments, avoid acquiring infections in hospitals, and prevent costly rehospitalizations, are not yet hardwired into routine care.

- *Too often, people receive care that is unnecessary, making the health system inefficient and wasteful.* Overuse of health care services – tests, procedures and treatments that are not needed – are not only expensive; they can result in complications, disability, and even death.[5] No one really knows how much of the health care dollar is spent on these unnecessary services but researchers estimate it accounts for around 30 percent of health care spending.[6]

- *Many Americans receive worse care than others.*[7] When it comes to health care, it matters whether you are rich or poor. But it also matters whether you are black or white, Hispanic or non-Hispanic, English-speaking or not. Evidence shows that care is worse for members of racial, ethnic and linguistic minorities, and the differences in care are not solely the result of differences in health insurance or income.[8]

ALIGNING FORCES FOR QUALITY: THE COMMITMENT

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

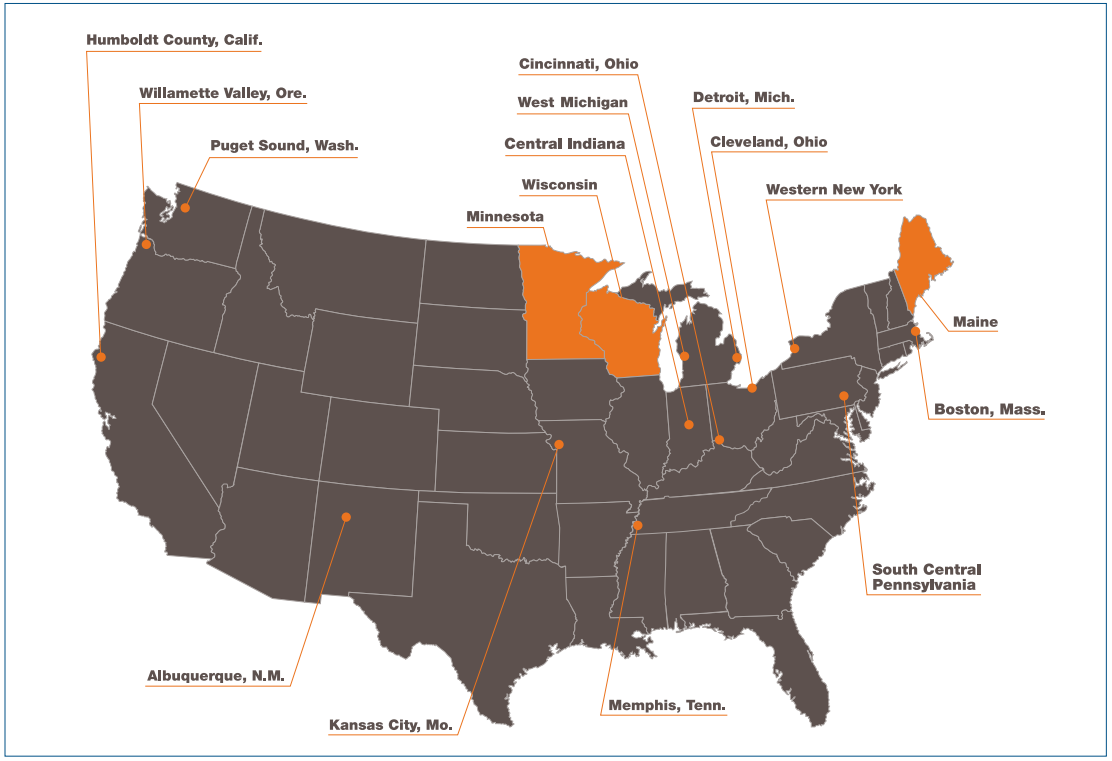
Although health care is a national problem, health care is delivered locally, and fixing it requires local action. In AF4Q, communities across the US, teams of stakeholders representing the people who get care, give care and pay for care are working to rebuild health care systems so they work better for everyone involved. The program intends to drive change in local health care markets that will result in measurable improvements by 2015.

Health care is delivered locally, but is influenced by local AND national factors.

AF4Q communities aim to create sustainable models of high-quality, patient-centered, equitable care within their own regions.[9] Their work will result in better health in the targeted regions, but also yield important lessons for other communities with the same passion and dedication to improve health care quality for their residents. Furthermore, the program will showcase models of improvement in quality that will hold lessons for advancing national quality efforts.

Aligning Forces began with four pilot sites in 2006 and now includes 17 communities[10] of

AF4Q Communities



various sizes and characteristics (see Table 1). Almost 38 million individuals live in Aligning Forces for Quality communities, stretching across 15 states and covering 253 counties. Over 35,000 primary care physicians practice in these communities, and the Robert Wood Johnson Foundation anticipates that more than half of these physicians – and many of the hundreds of hospitals – will be part of the Aligning Forces quality activities.

The Center for Health Care Quality within the Department of Health Policy at the George Washington University School of Public Health and Health Services serves as the national program office (NPO) for AF4Q. The NPO works in partnership with the Robert Wood Johnson Foundation to direct this far-reaching initiative. The NPO receives assistance from a cadre of technical experts in providing support to the 17 communities in a range of areas, tapping the best that the country can provide in the field of quality (see page 20 for a list of Aligning Forces Partners).

Achieving high-quality health care requires that those who give care, get care and pay for care be part of the solution.

Central to the AF4Q effort in these communities are local stakeholder groups charged with the task of making sense of the quality problem in America and meeting it with local solutions. Aligning Forces is based on the premise that moving quality forward is a complex undertaking, requiring involvement from a multitude of players. That's why work at the AF4Q community level is spearheaded by groups of stakeholders that broadly represent interested parties in the delivery, organization, payment and use of health care – organizations that have been active in the quality field; physicians, hospitals, and health plans; insurers, employers, and other payers; health departments and other public agencies; and consumer and other non-governmental organizations.

Table 1: **Aligning Forces for Quality Communities—Representing one in eight Americans, one in eight hospitals, and one in seven primary care physicians.[11]**

Site/Aligning Forces Alliance	AF4Q Service Region	Population	General Hospitals	Primary Care Physicians[12]
Albuquerque, NM *Albuquerque Coalition for Healthcare Quality*[13] http://www.abqhealthcarequality.org/	1 county (Bernalillo)	635,139	10	605
Boston, Massachusetts* *Health Quality Partners*; http://www.mhqp.org/	2 counties (Middlesex, Suffolk)	2,186,465	23	2,560
Central Indiana *Central Indiana Alliance for Health*	9 counties (Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Shelby)	1,774,665	18	1,404
Cincinnati, Ohio *Health Improvement Collaborative of Greater Cincinnati* http://www.the-collaborative.org/	8 counties in Ohio (Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren), 4 counties in Kentucky (Boone, Campbell, Grant, Kenton) and 2 counties in Indiana (Dearborn and Ripley)	2,235,551	26	1,747
Cleveland, Ohio *Better Health Greater Cleveland:* http://www.betterhealthcleveland.org/	1 county (Cuyahoga)	1,283,925	18	1,613
Detroit, Mich. *Greater Detroit Area Health Council;* http://www.gdahc.org/	7 counties (Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw, Wayne)	4,834,560	46	5,934
Humboldt County, Calif. *Community Health Alliance;* http://www.communityhealthalliance.org/	1 county (Humboldt)	129,000	4	116
Kansas City, Mo *Kansas City Quality Improvement Consortium;* http://www.kcqic.org/	2 counties in Kansas (Johnson, Wyandotte) and 3 counties in Missouri (Clay, Jackson, Platte)	1,658,400	25	1,589
Maine *Quality Counts;* http://www.mainequalitycounts.org/	Statewide (16 counties)	1,316,456	37	1,552
Memphis, Tenn. *Healthy Memphis Common Table* http://www.healthymemphis.org/	1 county (Shelby)	906,825	8	745
Minnesota *MN Community Measurement* http://www.mncommunitymeasurement.org/	Statewide (87 counties)	5,220,393	130	4,449
Puget Sound, Wash. *Puget Sound Health Alliance* http://www.pugetsoundhealthalliance.org/	5 counties (King, Kitsap, Pierce, Snohomish, Thurston)	3,829,763	29	3,399
South Central Pennsylvania *AF4Q South Central Pennsylvania; http://*www.aligning4healthpa.org/	2 counties (Adams, York)	525,702	4	486
West Michigan *Alliance for Health;* http://www.afh.org/	13 counties (Allegan, Barry, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa)	1,519,373	19	1,324
Western New York *P2 Collaborative of Western New York;* http://www.p2wny.org/	8 counties (Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)	1,529,043	24	1,120
Willamette Valley, Ore. *Oregon Health Care Quality Corporation* http://www.q-corp.org/	9 counties (Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill)	2,657,974	27	2,415
Wisconsin *Wisconsin Collaborative for Health Care Quality* http://www.wchq.org/	Statewide (72 counties)	5,627,967	130	4,550
Total	**253 counties**	**37,761,286**	**578**	**35,609**

** The Boston AF4Q service region includes all of Suffolk County and 46 zip codes in Middlesex County. The data in this table represents all of Suffolk and Middlesex counties.*

Source: US Census Bureau, Population Estimates Program, July 1, 2008.

These stakeholder groups in AF4Q have formed *Alliances* to manage their work under this initiative – non-profit organizations that integrate a variety of interests in the community along a common set of goals and activities. Alliances run the gamut from long-established endeavors like the Greater Detroit Area Health Council, which began in 1944 with the purpose of improving the management of community health resources,[14] to newly formed initiatives such as the Oregon Health Care Quality Corporation (Willamette Valley) – established in 2001 to help health care providers, payers, consumers and policymakers use information to improve quality and reduce costs.[15]

Tools and information on quality must be made available in American communities to engage patients in their care and help physicians improve.

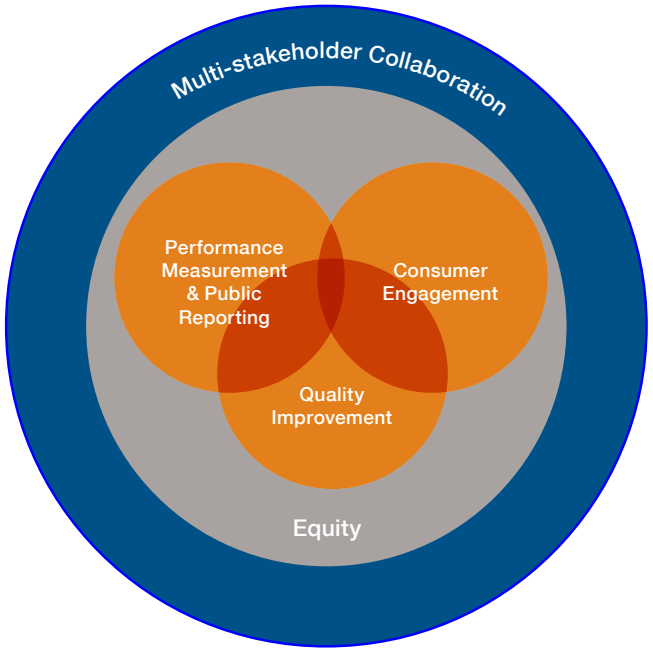
Aligning Forces for Quality is a bold experiment, designed to determine whether integrating various levers associated with health care quality can push improvements forward at a faster and more substantial rate than would be expected with any one of the individual initiatives alone. In each community, established or newly formed Alliances of stakeholders are charged with moving quality forward at the local level through activity in three important areas of focus:

1. **Performance measurement and public reporting:** using common standards to measure the quality of care that doctors and hospitals deliver to patients and making that information available to the public.

2. **Consumer engagement:** encouraging patients to be active managers of their health care, and make informed choices about their doctors and hospitals.

3. **Quality improvement:** implementing techniques and protocols that doctors, nurses and staff in hospitals and clinics can follow to raise the level of care they deliver to patients.

Aligning Forces for Quality Areas of Focus



Each of these domains holds promise for improving aspects of the health system.[16] But it is in the alignment of these activities that the goals of the initiative reside. The program has an additional objective – to make certain that health care, and any associated gains in quality, are equitable and that *all* residents in a community enjoy the benefits of high quality care. Tying it all together is the notion that multi-stakeholder collaboration is key in how Aligning Forces brings together major decision-makers around a common goal in a given region.

PERFORMANCE MEASUREMENT AND PUBLIC REPORTING ON QUALITY

Community reports comparing the quality of care provided in hospital and ambulatory settings serve at least two important functions: to spur quality improvement on the part of physicians and other health care providers; and to facilitate informed decision-making on the part of health care consumers. These reports comparing health care at the regional level are often referred to as "***community check-ups***" and provide a common foundation for everyone in the community to work together toward improved care for all residents.

AF4Q communities are proving that publicly reporting information about health care quality is possible.

As of July 2009, 14 of the AF4Q Alliances have produced public reports on the quality of ambulatory care in their communities, and the other three are well on their way to doing so. Each report addresses some measure of diabetes care and 12 of the 14 include measures of performance related to cardiovascular care. The publicly reported measures have all been endorsed by the National Quality Forum (NQF), the American Quality Alliance (AQA) or other nationally recognized measurement organizations.

The community check-up reports assess how physician practices, medical groups and, in some cases, individual physicians[17] in the community adhere to well-established quality care standards for certain chronic conditions. The reports reflect the collaborative efforts of quality organizations, physician practices and groups, health plans, consumers, and data management and aggregation services.

The actual process of creating a community check-up report in Aligning Forces includes several stages. At a minimum, Alliances must work with physicians in their communities to identify performance measures, collect and aggregate data, and display the information in a format that is useful and accessible to consumers, providers and others who are interested in the results. Physicians who participate in AF4Q reporting review the data prior to its release to the community. This provides an opportunity to make certain that the data are correct; it also offers physicians a chance to see how they perform relative to the health system as a whole.

Table 2: **Publicly Reported Ambulatory Performance Measures in AF4Q Communities, 2010**

	Diabetes Care	Cardiovascular Care	Cancer Screening	Other*
Boston	✓	✓	✓	✓
Cincinnati	✓		✓	✓
Cleveland	✓	✓		✓
Detroit	✓	✓	✓	✓
Humboldt County	✓		✓	
Kansas City	✓	✓	✓	✓
Maine	✓	✓		✓
Memphis	✓		✓	
Minnesota	✓	✓	✓	✓
Puget Sound	✓	✓	✓	✓
South Central PA	✓	✓		
West Michigan	✓			
Williamette Valley	✓	✓	✓	✓
Wisconsin	✓	✓	✓	✓

*Includes performance measures related to asthma, depression, prescription use, weight control, adult pneumococcal vaccines, and pediatric care (immunizations, well child visits, treatment of colds and testing for sore throats).

Background: The Evolution of Performance Measurement and Public Reporting

Over the last decade, public reporting of health care performance data at the national level has evolved and proliferated. Initially, public reporting efforts focused primarily on health insurance plans with the National Committee on Quality Assurance (NCQA) leading the way through the development of the Health Plan Employer Data and Information Set (HEDIS).[18] NCQA's HEDIS measures provide a tool for standardized measurement across health plans, so that health plans can compete on quality in addition to price. In recent years, more attention has been focused on the performance of individual providers, provider groups and hospitals. In 2002, hospitals accredited by the Joint Commission began collecting data on standardized performance measures as part of their accreditation process.[19]

The Medicare Modernization Act of 2003 included incentives for hospitals in the US to publicly report performance on a set of measures of hospital performance on the Hospital Quality Alliance's Web site, Hospital Compare. Hospital Compare now reports 10 measures capturing patient satisfaction with hospital care as well as 25 processes-of-care measures for approximately 4,200 acute care and critical access hospitals.[20]

Provider-level data has expanded in its availability from performance measures for a small subset of specialty physicians performing specific procedures, to a broader selection of measures for both primary care and specialty physicians.[21] Public reporting of hospital and provider-level data has also expanded to include patient experience measures, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.[22]

In addition to these national public reporting efforts, at least 28 states or regions have instituted their own public reporting initiatives.[23] These initiatives are often sponsored by health departments, state health data commissions and state Medicaid agencies and primarily report HEDIS and CAHPS data as well as other selected performance measures.[24]

Several multi-stakeholder coalitions have led efforts to vet, endorse and adopt performance measures to encourage unified and consistent public reporting across health care organizations. Since 1999, the National Quality Forum (NQF) has endorsed "consensus-based national standards for measurement and public reporting of healthcare performance data."[25] Formed in 2004, the Ambulatory Quality Alliance (AQA) works to improve performance measurement, data aggregation and reporting in the ambulatory care setting. Since 2006, the Quality Alliance Steering Committee (QASC) has been working as a collaborative effort to coordinate and build the initial components of an infrastructure to collect health quality and cost data nationwide in order to improve the quality and efficiency of health care.[26] NQF, AQA and QASC are all working to spur adoption and implementation of performance measurement.

All of the Alliances have used processes to develop these reports that are transparent and highly collaborative.

The reports issued by AF4Q communities vary in their content, format and dissemination from site to site – providing an interesting set of examples for the nation from which to learn about effective communication of physician and health system performance at the community level.

At a glance, the AF4Q Alliances have varying experiences in terms of their history with public reporting. The three Alliances that represent statewide efforts (Maine, Minnesota and Wisconsin)[27], for example, have each been reporting performance data to their communities for more than five years while other Alliances issued their first community reports in 2009.

Alliances also use a variety of methods to gather the data used for reporting and vary in terms of the types of measures and sources used in their reports. In Wisconsin, the Alliance's community check-up report uses data that come primarily from electronic medical records. Some of the AF4Q Alliances that are releasing their second, third, or even sixth report have added new measures or stratified established measures by various population characteristics. For example, Puget Sound's third community check-up report, released in July 2009, compares results from Medicaid and commercially insured patients.[28] Cleveland's fifth community health check-up report, released in June 2010, compares performance stratified by the race and ethnicity of patients, as well as their type of coverage or lack of insurance.[29]

Cincinnati

In every AF4Q community, information about the quality of care being provided locally is helping doctors improve their care, and helping patients make better choices. One physician leader in Greater Cincinnati told AF4Q leaders that knowing that his practice's performance data will be made public in the near future has caused him to increase his reliance on literature to make sure he is "doing everything in an evidence-based way." He has stopped assuming he is doing things correctly and is now taking time to review nationally recommended measures for high-quality care. As a result, he says he has changed how he and his staff care for their patients with diabetes.

Public reports of quality are reaching patients and physicians in AF4Q communities in tangible ways.

The AF4Q communities that have released public reports of quality are already seeing exciting results in terms of patients and physicians who are accessing this information. Many communities are adding new information, seeking new audiences and some are even starting to see the beginnings of an impact on care. Here are just a few examples of how AF4Q Alliances' efforts are affecting their communities' understanding of the quality of care being provided locally:

- People with diabetes in Cleveland can now compare adherence to recommended care measures at more than 40 primary care practices across the region – and it is having an impact on care: the percentage of providers meeting all four care processes monitored – including blood sugar testing, kidney screening, eye exams and pneumonia vaccination – increased from 41 percent to 46 percent between 2007 and 2009. (www.betterhealthcleveland.org)

- In Detroit, for the first time ever, the quality of care provided by more than 80 percent of primary care physicians practicing in the region's 15 major physician organizations is being tracked – providing easily accessible data on how they meet national measures for

diabetes care, cancer screenings, pediatric care and asthma care. (www.mycarecompare.org)

- A 2009 report in Oregon is the state's most comprehensive report on the quality of primary care in the state. The report summarizes care delivered by 2,212 primary care practitioners and establishes a baseline against which Oregon can measure its progress toward improving health care. To follow-up on the statewide report, a second report in 2010 now allows consumers to view and compare quality scores of individual provider groups and clinics. (www.partnerforqualitycare.org)

- In Kansas City and Memphis, health care leaders worked with Consumers' CHECKBOOK to survey local residents on how satisfied they were with their care experiences with their physicians.[30] Information for 713 doctors in Kansas City and 437 doctors in Memphis is now available in a searchable online database. (www.checkbook.org/patientcentral)

- AF4Q leaders in Minnesota have publicly reported 14 clinical performance measures for more than 170 medical groups representing more than 300 clinics statewide. They also have reported results on patient experience of care from a pilot study with 124 participating clinic sites from across Minnesota. Minnesota is also developing specialty measures as well as measures designed to identify overuse of certain services (consistent with priorities defined by the National Priorities Partnership).[31] (www.mncm.org)

- Puget Sound residents now have access to a comprehensive report on health care performance in the region, including 76 medical groups, nearly 240 clinics and 30 hospitals in King, Kitsap, Pierce, Snohomish and Thurston counties. The report also rates health plans in the region against national quality standards. (www.wacommunitycheckup.org)

ENGAGING CONSUMERS IN THEIR HEALTH CARE[32]

As American consumers are increasingly being called upon to more actively engage in their health care, Aligning Forces communities are working to arm consumers with the information that they need to do so. The goal of the consumer engagement focus in AF4Q is for consumers to access and use health and comparative performance information to make informed health care decisions at key points. To reach this overarching goal, AF4Q articulates specific consumer engagement expectations to guide local initiatives over the next several years. Alliances are encouraged to include consumers in their leadership activities, provide consumers access to consumer-friendly health and comparative performance information (most notably through their public reports), and partner with providers, purchasers and insurers to implement strategies to activate consumers.

AF4Q Alliances are making information about the quality of care available to consumers in their communities more accessible.

A critical part of AF4Q Alliances' consumer engagement efforts is framing and portraying publicly reported information on health system performance in formats that are accessible and meaningful to individuals as they work to manage their health conditions and secure the health care they need. Several of the Alliances have devoted substantial energy to developing Web sites that display health system and physician performance information in consumer-friendly formats.

Background: Consumer Engagement

Individuals are increasingly being called on to play a role in improving the quality of care delivered in the US by becoming informed and engaged health care consumers who demand high quality care.[33, 34] Although conceptually a simple task, moving consumers from passive recipients of health care to active, engaged agents in the health care system can be extremely challenging.

Consumers cannot make informed decisions about health care unless information is accessible, useful and meaningful. For this reason, efforts are underway across the country to facilitate consumer engagement by making health information more consumer-friendly and enabling consumers to be more proficient in navigating the health care system.

Key to consumer engagement efforts is ensuring the availability of consumer-friendly health and comparative performance information. Such reports must feature design and navigation tools that increase their value and accessibility to consumers. Consumer reports should inform key health care decisions, including choosing a provider, such as a physician, hospital or health plan; choosing a particular treatment or procedure; or choosing to educate oneself about a particular health condition and appropriate, evidence-based standards of care.

Consumer engagement efforts also include strategies to drive consumers to use such health and comparative performance information. Organizations such as the National Partnership for Women & Families have developed programs to empower patients to be informed consumers by teaching them how to utilize comparative performance reports to make informed health care decisions and providing strategies to partner with health care providers.

Health care providers, purchasers, and insurers also have a role to play in encouraging and incentivizing consumers to access and use health and comparative quality information. Health care providers can partner with patients and encourage patients to use health and quality information in making health care decisions. Employers, who often act as purchasers, can incentivize consumers (i.e. with lower premiums) to select high-performing health plans. Health plans can offer consumers benefits, such as lower co-pays, for selecting high-performing providers.

AF4Q has developed guidance for Alliances as they work to make their community check-up reports consumer-friendly. Namely, AF4Q reports aim to apply consumer-friendly characteristics, including:

1. Communicating a definition of quality that is understandable and relevant to consumers
2. Having measures that are meaningful to consumers, transparent, and meet widely accepted, rigorous criteria
3. Being seen by consumers as having credible data and sponsored by a trusted source
4. Having information that helps consumers understand the meaning and importance of specific measures
5. Helping consumers understand and use comparative performance information in making choices
6. Being Web-based, which is preferred to other more static modes
7. Employing layering and navigation aids so that consumers are not overwhelmed with information or required to look at information that is of lesser interest to them
8. Offering consumers guidance on specific ways to use the information, especially to make decisions, but also to interact with providers and families

9. Guiding consumers in how to understand information on cost and efficiency and how it can be integrated with quality measures to make informed decisions

10. Testing with consumers for format, language and structure

AF4Q Alliances are incorporating these characteristics into their public reports and Web sites in a variety of ways and are seeking to gauge what constitutes "consumer-friendly," accessible information for residents in their communities. Alliances are tracking the extent to which Web sites and performance reports are accessed and downloaded by consumers and others in the community.

Alliances are also working with consumers to ensure that they are reporting measures that are useful and meaningful. As Alliances work to release updated versions of their public reports, many are conducting research with consumers to determine which measures would be most valuable to them in making informed decisions about their care.

Since publishing their first public reports and continuing to expand the data that are available, several communities are making the complex information easier to use. The Maine AF4Q Alliance is in the midst of a project to thoroughly redesign its public reporting format, to ensure the display method evolves with the complexity of the data. In its first public report, Memphis included performance information using a four-star rating system for the more than 50 practices represented in the data. Memphis recently redesigned its Web site to provide information targeting specific stakeholder groups, including consumers, providers and payers. Willamette Valley is one of several Alliances looking at issues related to health literacy, at times adjusting the reading level of publicly reported information and ensuring it is written in plain language and is understandable to consumers – they've assembled advocates and other community groups to test materials, hone messages and solicit suggestions about ways to best disseminate the public report.

AF4Q communities are leveraging consumer engagement activities to help patients become partners in their own health care.

In addition to efforts to make health care quality performance information accessible to consumers, AF4Q Alliances are working to provide their communities with tools to more actively engage consumers in their care. Although varied in their approach, several Aligning Forces communities have tailored their initial activities to the most pressing needs in their regions – including consumers with the most complex conditions,

Western New York

Daryl Rasuli is a consumer engagement associate hired by the P2 Collaborative, the organization implementing AF4Q efforts in Western New York, to help educate patients about diabetes care measures and resources available to them in the community (including the physician performance report to be released next year). Daryl is responsible for patients in Buffalo zip code 14215, which is home to a largely uninsured, minority population on the city's east side. Daryl goes door to door (as well as working with church groups) to share information. He has been amazed at how many resources there are in the community to help people manage their diabetes. But he is equally amazed that no one has ever aligned all the disparate resources before and provided them to these vulnerable patients and neighborhood leaders in a simple, holistic resource. He says the patients he meets are learning an incredible amount about how to care for their disease and what they should expect from their doctors.

requiring ongoing care and interaction with the health care system. Diabetes, for example, is a focus for many communities that have worked to disseminate some comprehensive tools for residents:

- More than 100,000 people with diabetes in Greater Cincinnati have received a toolkit as a part of the Diabetes Footprints campaign (www.diabetesfootprints.org), to help them better understand what constitutes quality care for their condition and help them improve communication between patients and their doctors. Tools provided on the Web site include a provider checklist and patient self-care checklist, among other resources. Messages and key talking points provided through the Web site are supported in radio and print media.

- In Humboldt County, hundreds of residents have enrolled in the free Pathways to Health workshops that aim to help people become better self-manager of their chronic conditions. Individuals with diseases like diabetes and high blood pressure can join the program, which helps them set attainable, healthy goals.

- More than 10,000 Minnesotans with diabetes are being encouraged to use a library of informational tools (available at www.thed5.org), so they and their doctor can meet the aggressive treatment goals that clinicians consider vital to managing the disease. The program encourages patients to strive for five goals to attain ideal diabetes management, known as the D5. A D5 score represents the percentage of diabetes patients achieving the D5 (a composite measure of care).

- Detroit has developed a tool, *the Employer Commitment Form*, to encourage employers to make a commitment to provide publicly reported performance data to their employees. The Alliance has also developed employer toolkits to provide resources and communication tools to assist employers in disseminating public report information to their employees. These and related tools are being distributed broadly throughout the community to encourage patient involvement and engagement around high-quality diabetes care.

- South Central Pennsylvania launched the I Can! Challenge**,** a free 12-week program to improve the health of people with diabetes or heart disease through: 1) strengthening relationships with providers; 2) understanding their condition; 3) changing lifestyle and behavior; and 4) using quality data. Television coverage of the challenge carried messages around achieving these goals to more than 20,000 viewers.

IMPROVING QUALITY IN HOSPITAL AND AMBULATORY SETTINGS

As AF4Q Alliances release public reports, build on performance measurement, create reporting formats that are accessible and meaningful for consumers, and engage consumers in using health information, quality improvement (QI) becomes an increasingly important dimension in the overall efforts to improve quality of care. Physicians, health plans and hospitals are incorporating quality improvement strategies in their efforts to use information to propel quality forward in AF4Q communities.

In some cases, Alliances are tapping into existing quality improvement activities that are consistent with the focus of the performance measurement and consumer engagement strategies. Other Alliances are just beginning to address quality improvement in a comprehensive way.

To support champions and leaders in each community to create sustainable infrastructure for continued improvements in outpatient care, Aligning Forces launched the Ambulatory Quality Network in October 2009. The Network facilitates peer-to-peer learning by allowing leaders from across the communities to share strategies, tested tools and resources, as well as innovations.

Background: Quality Improvement

Industries have used quality improvement processes for decades to reduce waste, improve efficiency and better serve their customers. W. Edwards Deming first introduced quality improvement techniques to Japanese automobile executives following World War II. Deming's methods transformed automobile manufacturing, resulting in higher quality, faster production speed, and lower costs.[36]

More recently, these concepts have been applied to health care in order to drive sustainable change. Quality improvement efforts in health care aim to bridge the gap between ideal and actual care.[37] Quality improvement tools that have been vetted in other industries have since been applied to improve health care. Methodologies, including the Plan-Do-Study-Act (PDSA), Lean, SixSigma, and the Breakthrough Series model, have been particularly successful in the health care setting.

PDSA employs rapid-cycle learning through trial and error, which allows for continued improvement and understanding with each cycle. This method relies on teams to identify problems, implement potential solutions, measure and evaluate the results, and then based on review of the results decide what interventions to try next.

The Lean system is designed to eliminate waste and waiting and is often employed to improve patient flow. Lean aims to reduce three types of waste: **Muda** which represents overproduction or non-value adding work, **Muri** which represents overburden or unreasonableness for the capability of a person or equipment, and **Mura** which represents unevenness in production or flow.[38] Lean involves redesigning the whole system in order to improve patient flow from the time the patient enters the door until he/she is discharged.

SixSigma relies on data collection and statistical analyses to reduce errors and variation. Sigma represents standard deviation, so the idea behind this methodology is to identify defects in processes of care and work to improve those processes in order to eliminate deviations from the standard.

The Breakthrough Series uses a collaborative approach over six to 15 months to bring together health care teams to learn from each other in order to improve quality in a focused topic area. Breakthrough Series methodology has been used to reduce wait times, prevent worker absenteeism, reduce ICU costs, and reduce hospitalizations in heart patients.[39]

Cleveland

Changing workflows in busy practices can be challenging. Dr. Jim Misak, a family practice physician at one of the MetroHealth System's community health centers in Cleveland, decided to start by changing his own. Electronic medical records can be a great tool for managing patients, and Dr. Misak knew he'd have to change his routine to take full advantage of it. He made it a habit to review the health maintenance field in his electronic medical record system for every encounter with every diabetic patient – even if there was no alert to grab his attention. For each patient with diabetes, he would review the health maintenance field and write orders for needed tests before the visit, so he wouldn't forget. The result was a remarkable improvement in his achievement on Better Health Greater Cleveland's Process of Care composite standard, which includes four measures of quality care. Seventy-three percent of Dr. Misak's patients achieved the standard – head and shoulders above the four other doctors in the practice and 46 percent above his own scores a year earlier.

AF4Q Alliances are tackling the critical challenge of building a sustainable regional infrastructure for ambulatory care quality improvement.

Current ambulatory care QI activities are varied in terms of sponsorship, scope and status, both within and across AF4Q communities – again, providing an array of examples from which the rest of the country can learn. Depending on where they are located and the specific initiative, these efforts include health plans, hospitals, medical groups, employer groups, departments of health, federally qualified health centers, federal and state agencies, medical associations and private foundations:

- Several Alliances are located in communities that have developed and/or participated in a quality improvement collaborative, often using the Institute for Healthcare Improvement's Breakthrough Series as a model for improvement.[40] For example, Cincinnati's Primary Care Innovations Group is using the IHI Breakthrough Series to assist providers in redesigning office visits.

- In Western New York, Practice Engagement Associates (RNs trained in assisting practices) – referred to as PEAs, work closely with practices to implement QI initiatives. Among other activities, the PEAs collect data and assist with performance reporting, data tracking and practice-based research, and also share lessons across participating practices.

- Several Alliances, including those in Maine, Michigan, Minnesota, Puget Sound, South Central Pennsylvania and Wisconsin, are participating in the Improving Performance in Practice (IPIP) initiative coordinated by the American Board of Medical Specialties.[41] As IPIP participants, providers in these communities receive technical assistance from quality improvement coaches who have been trained in quality improvement methods and aim to help practices redesign their approach to quality improvement activities.

- The creation of a medical home is a central goal of many of the Alliances' QI efforts. In 2009, Cincinnati and Maine kicked off their multi-payer patient-centered medical home demonstration projects.

- The Primary Care Renewal program in Humboldt County is improving ambulatory care while increasing staff job satisfaction and retention. As part of the program, medical teams (including physicians, medical assistants (MAs), nurses and administrative staff) from more than half of Humboldt County's primary care practices attend regular meetings to talk about implementing systems that can improve the quality of care they deliver. Through

this program, MAs have taken on a more meaningful role in the practices by monitoring disease registries, calling patients to schedule missed tests or exams, flagging important patient information for physicians, or providing patient education. Some have said that they are helping to save lives by noticing when patients have missed a screening or procedure and following up to make sure that they receive them.

Not surprisingly, health information technology (HIT) plays a central role in many of the Alliances' quality improvement efforts and in making the data and information accessible to drive improvement. Here are just a few examples of how AF4Q communities are using HIT efforts to improve care in their regions:

- West Michigan's Alliance for Health assisted a physician organization in creating a patient registry focusing on 15 diabetes metrics, as well as metrics for other conditions.
- Cincinnati's HealthBridge program makes available clinical data such as lab results and hospital discharge summaries over the internet and delivers clinical results to more than 4,800 physicians.
- Thirty-one of the 44 practices reporting performance information in Cleveland use electronic medical records (EMR). These practices account for 89 percent of the 22,777 patients with diabetes whose quality of care is reported. The federally qualified health centers in Cleveland that do not yet have an EMR are in the process of acquiring and transitioning to an EMR-based system. These systems facilitate the reporting of data, including the stratification of performance by race and ethnicity.

Hospitals in AF4Q communities are joining the effort to improve care in the inpatient setting by making a commitment to high-quality care for all patients.

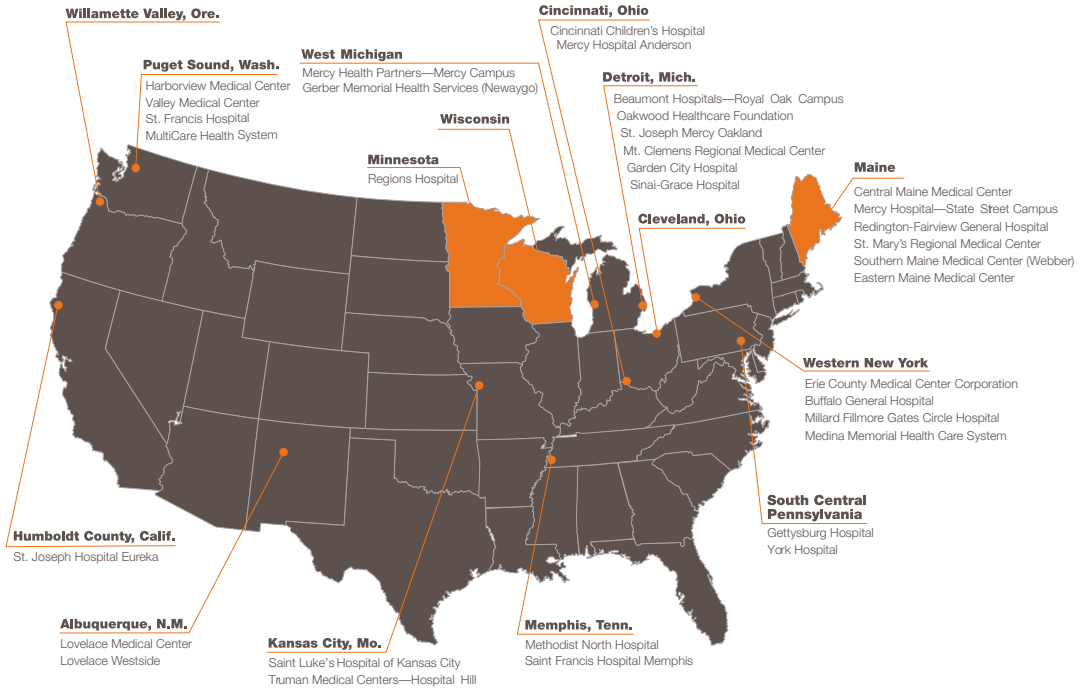
Through the AF4Q Hospital Quality Network, communities are also engaging hospitals in quality improvement initiatives aimed at increasing the role of nurses, reducing disparities in care and providing equitable, high-quality care for all patients. Through their participation in one of four areas for quality improvement hospitals across the AF4Q communities have committed to increasing the quality and efficiency of care in medical-surgical units – where most of the country's inpatient care is delivered and where up to 40 percent of unexpected hospital deaths occur.[42]

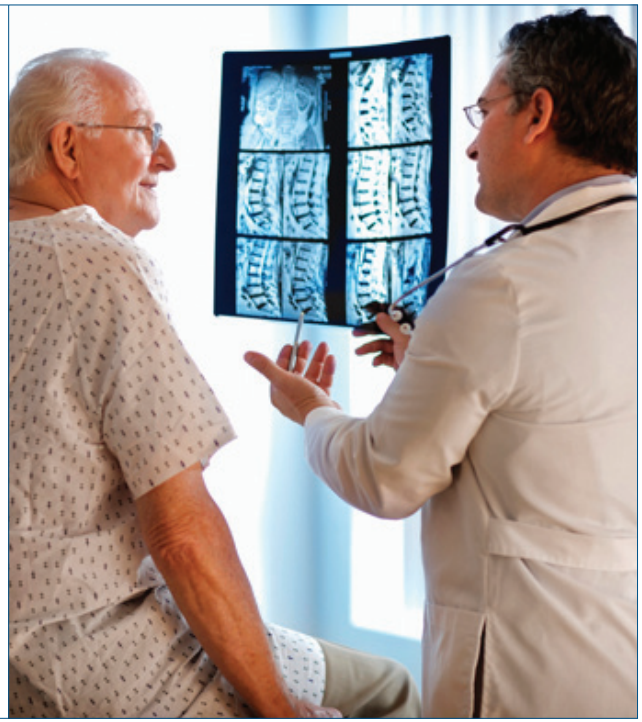
As the Hospital Quality Network continues to expand within the communities, hospitals currently participating in the program are seeing impressive improvements – Western New York's Erie County Medical Center, for example, set a goal to reduce pressure ulcers on their medical-surgical unit to zero, and through the TCAB method whereby nurses design, test, institute and track their own quality improvements, met the goal within one month.

Information on these initiatives and participating hospitals can be found below:

- *Transforming Care at the Bedside (TCAB):* Eighteen hospitals in AF4Q communities are participating in TCAB, a program designed to systematically measure and enhance the quality of nursing care provided to patients. The goal of the collaborative is to engage front-line hospital nurses and leaders at all levels of the organization to improve the quality and safety of patient care on medical and surgical units; increase the vitality and retention of nurses; engage and improve patients' and family members' experience of care; and improve the effectiveness of the entire care team. (www.rwjf.org/goto/nursingtoolkit)
- *Reducing Readmissions*: Eight hospitals are engaged in a program to systematically measure and enhance the quality of cardiac care provided to their patients. The goal of the collaborative is to engage health care providers and leaders at all levels of the health

AF4Q Hospital Quality Improvement Collaboratives





care organization in an effort to improve the quality of care delivered to all patients with acute myocardial infarction and heart failure while reducing racial and ethnic disparities. Participating hospitals must standardize the collection of patient race, ethnicity and language (REL) data across the organization. The program builds upon the accomplishments from the RWJF-funded *Expecting Success: Excellence in Cardiac Care* program. (www.rwjf.org/goto/expectingsuccesstoolkit)

- *Improving Language Services*: Nine hospitals are involved in a program using a tested, rigorous quality improvement measurement process to look at how hospitals communicate with non-English-speaking patients and how the hospitals can improve their services. The goal is to engage clinicians, language services providers and leaders at all levels of the health care organization to improve the delivery and availability of language services for persons with limited English proficiency (LEP); improve the safety of LEP patient care; and implement performance measurement to improve language services. Hospitals report on performance measures that address screening for preferred language for health care, the delivery of language services by qualified personnel, timeliness of service, productivity of interpreters, translation of written materials and a measure to compare service delivery for LEP patients and non-LEP patients. The program builds upon the success of the RWJF-funded *Speaking Together: National Language Services Network* program. (www.rwjf.org/goto/languagetoolkit)

In October 2010, Aligning Forces will launch a program aimed at improving patient flow through Emergency Departments (ED). Hospitals will engage health care providers at all levels of the organization to improve ED throughput time and reduce racial and ethnic disparities. The program builds upon the success of the RWJF-funded *Urgent Matters* program (www.urgentmatters.org).

Through the breadth of ambulatory and hospital-based QI activities, Alliances seek to complement and build on the unique public reporting, performance measurement and consumer engagement activities already taking place in the communities.

A FOCUS ON EQUITY

Racial and ethnic disparities are any differences in measures of health and health care among populations.[43] Disparities represent failures in health care quality that must be addressed in order to provide ideal care. A necessary step in reducing disparities is understanding who the patient population is through the collection of self-reported race, ethnicity and language information.

The AF4Q Alliances are working to reduce racial, ethnic and linguistic disparities in their

Background: The Collection of Race, Ethnicity and Language Data

In 1999 Congress requested an Institute of Medicine (IOM) study to assess racial and ethnic disparities in health care. The IOM's 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* documented significant variations in care by race, regardless of income, coverage, and other socioeconomic factors. The report found that racial and ethnic minorities tended to receive lower quality of health care than non-minorities across a variety of health care settings.[44] The IOM report included a number of recommendations to address these disparities, including the collection of standardized data.

Over the past few years, three standards-setting organizations have addressed the collection of race, ethnicity and language data as part of a more comprehensive effort to improve the delivery of care to diverse populations. In 2009, NQF endorsed preferred practices,[45] including a toolkit developed by the Health Research and Education Trust (HRET) on ways to collect race, ethnicity and language data.[46] In December 2008, NCQA released a set of standards for public comment for assessing the quality of culturally and linguistically appropriate care, which include standards for data collection. The Joint Commission is also actively engaged in a process to develop new standards for culturally competent, patient-centered that also include expectations around the collection of race, ethnicity and language data. The Office of Minority Health's Standards for Culturally and Linguistically Appropriate Services in Health Care[47] have served as the foundation for many of these initiatives.

The IOM's recently released report *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* affirms the importance of collecting standardized REL data.[48] The new report provides guidance for implementing standardized data collection by race, Hispanic ethnicity, granular ethnicity and language need to improve quality and reduce disparities.

The American Recovery and Reinvestment Act of 2009 supports REL data collection through HIT investments. The legislation includes funding to support the development of electronic data collection methods for the collection of race, ethnicity, primary language and gender data to understand and improve disparities in care.

communities and incorporating this goal into their performance measurement, quality improvement and consumer engagement activities. In pursuit of this important goal, the Alliances are embarking on initiatives to encourage physicians and providers to collect self-reported race, ethnicity and language information and to begin stratifying performance data by these patient characteristics.

- Cincinnati is engaged in an initiative modeled after the Robert Wood Johnson Foundation's *Expecting Success* program that targets all of the hospitals in the Alliance's area. In the first phase of the project, hospitals assessed race, ethnicity and language data collection practices across hospitals that are members of the Greater Cincinnati Health Council. The result is nearly 20 hospitals in the area have agreed on the methods and measures to gather consistent data. Hospital admissions and registration staff were then trained to collect self-reported patient race, ethnicity and language data. This is a key step in the Alliance's work toward identifying and addressing any disparities in the region.
- Better Health Greater Cleveland is stratifying its publicly reported performance measures by race and ethnicity to track improvements over time and make certain they address any disparities in care. In 2011, the Alliance will also stratify performance by patients' preferred language.
- MN Community Measurement developed a handbook on the collection of race, ethnicity and language data for medical groups. The handbook establishes a standard set of data elements to be collected by medical groups and clinics participating in the Minnesota Alliance's data collection program. The handbook also makes the case for collecting REL data and provides tips on how to establish successful data collection systems and how to use the data to improve quality. The handbook is available at: http://www.mncm.org
- The Alliance for Health in West Michigan worked with six hospitals belonging to two systems to begin collecting data on the race, ethnicity and language of patients and has been

working to inform local community members about the goals of data collection. Registration staff at the six hospitals were trained on consistent methods to track the information, which will enable the region to take a comprehensive look at the prevalence of disparities in care.

- Central Maine Medical System, the largest in New England with 300 physicians, implemented REL data collection system-wide including all office physician practices. CMMC, in partnership with the Maine AF4Q Alliance, the Maine Hospital Association, as well as other regional organizations, also trained hospitals across the state in standardized REL data collection.

AF4Q COMMUNITIES AS LEARNING LABORATORIES FOR REFORM

The AF4Q work reflects many of the goals of a reformed health care system: greater transparency, activated consumers, equity and ongoing quality improvement.

Since the official launch of the program in June 2008, Alliances have set the stage for transformational change on the local level, where care is delivered and influenced.

As local, state and federal entities embark on implementing health care reform provisions from the Patient Protection and Affordable Care Act, Aligning Forces communities serve as learning laboratories that help inform the process.

Already, Alliances are leveraging local partnerships to take advantage of national and state opportunities for reform, particularly in HIT. Eleven Alliances are involved in the HIT Regional Extension Centers set up by the Office of the National Coordinator on HIT, helping accelerate the adoption of electronic records in their communities. Several other Alliances are also involved in the Beacon Community Cooperative Agreement Program that aims to build and strengthen HIT and health information exchange infrastructure.

By bringing everyone to the table – those that get care, give care and pay for care – Aligning Forces communities are demonstrating that a productive dialogue, one that generates real solutions to the quality problem in America is possible.

In Detroit, Jerry Frankel is a family doctor who heads Oakland Southfield Physicians, an association of more than 350 primary care doctors who provide care throughout the greater Detroit area. Many of them treat a largely underserved population. Although he is the CEO of this powerful alliance, Dr. Frankel says that he never before had the opportunity to speak with all of the health plans working in the Detroit market all at once, until the AF4Q effort pulled them together. Coming face to face with all the other stakeholders on a routine basis has helped him think and talk about perspectives of purchasers and payers. Working through AF4Q has helped him better "understand the others, like the big three autos, the unions" in learning what they need from providers in the local health care system. He says he "suddenly got the big picture" and realized that they all need to share their perspectives and work together if they want to change the local health care market and improve quality.

TOOLS FOR TRANSFORMING HEALTH CARE QUALITY

A comprehensive collection of tools and resources for improving the quality of health care in your community can be found online at the Robert Wood Johnson Foundation's Quality/Equality Web site.

- A presentation builder for "Talking about Quality" with various stakeholders.
- Snapshots of Aligning Forces communities and the multi-stakeholder Alliances leading their efforts.
- Interactive toolkits for improving the quality of care for racial and ethnic minorities, and positioning nurses to lead quality improvement efforts in hospital settings.
- Video and audio stories from local leaders in the health care quality improvement movement.
- Visit http://www.rwjf.org/qualityequality/af4q/

Aligning Forces for Quality: Select Partners in Technical Assistance

Alliances are receiving targeted technical assistance from organizations and consultants who provide expertise to support the many activities associated with Aligning Forces for Quality:

American Institutes for Research provides technical assistance which focuses on Alliances' efforts to effectively display comparative performance data to the public and to engage audiences in the use of that information in order to better engage consumers and facilitate informed decision-making. (www.air.org)

American Organization of Nurse Executives provides technical assistance to hospital teams from AF4Q communities participating in the AF4Q Transforming Care at the Bedside quality improvement collaborative. (www.aone.org)

Center for Health Care Strategies offers Alliances opportunities to engage Medicaid stakeholders in AF4Q activities, including the collection of race, ethnicity and primary language data to stratify Medicaid performance and use the information to support the key domains of the AF4Q program. CHCS also provides technical assistance to facilitate the collection of race, ethnicity and language data by health plans in AF4Q communities. (www.chcs.org)

Health Information Technology Resource Center works with Alliances on a variety of HIT related activities.

Leadership in Action Program provides customized technical assistance to AF4Q Alliance leadership teams on the execution and performance management of AF4Q community work. (www.aecf.org)

MacColl Institute provides technical assistance for a range of Alliance ambulatory quality improvement initiatives and is identifying models in other parts of the country that could provide lessons for AF4Q communities. (www.improvingchroniccare.org)

National Committee for Quality Assurance provides expertise to AF4Q Alliances on various aspects of quality measurement. (www.ncqa.org)

National Partnership for Women & Families assists Alliances in recruiting, educating and supporting consumer advocates in AF4Q communities to participate in efforts to promote better quality health care. (www.nationalpartnership.org)

National Quality Forum offers assistance to the AF4Q communities to further develop a regional model for performance measurement. (www.qualityforum.org)

Penn State University serves as the evaluator for Aligning Forces for Quality. Led by Dennis Scanlon, PhD, a team of investigators conducts research on efforts to align incentives across the various stakeholders in each market community involved in the program.

REFERENCES

[1] Aaron HJ, Ginsburg PB. Is Health Spending Excessive? If So, What Can We Do About It? *Health Affairs* 2009; 28(5):1260-1275

[2] The uninsured and the difference health insurance makes. Washington, DC: The Henry J. Kaiser Family Foundation, September, 2009. <http://www.kff.org/uninsured/upload/1420-11-2.pdf>

[3] McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. June 2, 2003. The quality of health care delivered to adults in the United States. *NEJM* 348 (26):2635-45.

[4] Kohn, Corrigan, Donaldson, Editors; Institute of Medicine Committee on Quality of Health Care in America. To Err Is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.

[5] Bodenheimer T. The American Health Care System: The Movement for Improved Quality in Health Care. *NEJM* 1999; 340(6):488-492.

[6] Levine RA. Fiscal Responsibility and Health Care Reform. *NEJM*.org, August 26, 2009.

[7] Agency for Healthcare Research and Quality, National Healthcare Disparities Report – 2008, Pub no. 09-0002, March 2009.<http://www.ahrq.gov/qual/qrdr08.htm> (accessed August 13, 2009).

[8] Smedley BD, Stith AY, Nelson AR; Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press; 2003.

[9] Painter MW, Lavizzo-Mourey R. Aligning Forces For Quality: A Program To Improve Health And Health Care In Communities Across The United States. *Health Affairs* 2008; 27(5):1461-1463

[10] Two additional pilot sites (Boston, MA, and Central Indiana) were added to Aligning Forces for Quality in 2010.

[11] U.S. Census Bureau, Population Division, August 05, 2009; AHA, Fast Facts on US Hospitals, 2007; GAO, Primary care professionals, 2008.

[12] Includes doctors of osteopathy.

[13] Albuquerque is the newest community to join the AF4Q program. Activities of the Albuquerque Coalition for Healthcare Quality will be profiled in future reports.

[14] For more information about the Greater Detroit Area Health Council, see: http://www.gdahc.org/about.asp?ContentID=30

[15] Scanlon D, et al. Aligning Forces for Quality in Willamette Valley, Ore.: A Community Snapshot. Penn State University Center for Health Care and Policy Research, March 2009.

[16] The evidence supporting public reporting, consumer engagement and quality improvement as mechanisms for health system change is mixed. See: Fung CH, Lim Y-W, Mattke S, Damberg C, Shekelle PG. Systematic review: The Evidence that publishing patient care performance data improves quality of care. Ann Intern Med 2008; 148: 111-123. Faber M, Bosch M, Wollersheim H, Leatherman S, Grol R. Public Reporting in Health Care: How do consumers use quality-of-care information? Medical Care 2009; 47(1): 1-8. Nilsen ES, Myrhaug HT, Johansen M, Oliver S, Oxman AD. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. Cochrane Databases of Systematic Reviews 2006; 3. Hurley RE, Keenan PS, Martsolf GR, Maeng DD, Scanlon DP. Early experiences with consumer engagement initiatives to improve chronic care. Health Affairs 2009; 28(1): 277-283. Schouten LMT, Hulscher MEJL, van Everdingen JJE, Huijsman R, Grol RPTM. Evidence for the impact of quality improvement collaboratives: systematic review. BMJ 2008; 336:1491-1494.

[17] Most of the public reports present information at the medical group or practice level. The P2 Collaborative in Western New York plans to report data at the individual physician level. Other reports may include individual physician performance if that individual physician is a medical group of one.

[18] Bodenheimer T. The American Health Care System: The Movement for Improved Quality in Health Care. *NEJM* 1999; 340(6):488-492.

[19] Siegel B, Regenstein M, Jones K. Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care. New York: The Commonwealth Fund, January 2007.

[20] Laschober, M. Potential Challenges in Public Reporting for Hospitals. Mathematica Policy Research, Inc. 2006: 2. <http://mathematica-mpr.com/publications/pdfs/hospcompare.pdf>

[21] Narins CR, Dozier AM, Ling FS, Zareba W. The influence of public reporting of outcome on medical decision making by physicians. Arch Intern Med 2005; 165: 83-87

[22] www.cahps.ahrq.gov

[23] State health care performance public reporting activity. National Partnership for Women and Families, 2008. <http://www.nationalpartnership.org/site/DocServer/State_Performance_Reporting_chart_2008.pdf?docID=3101>

[24] State health care performance public reporting activity. National Partnership for Women and Families, 2008. <http://www.nationalpartnership.org/site/DocServer/State_Performance_Reporting_chart_2008.pdf?docID=3101>

[25] Lang NM, Kizer KW. Public policy: National Quality Forum, an experiment in democracy. *Journal of Professional Nursing* 2003; 19(5): 247-248

[26] Quality Alliance Steering Committee Web site. <http://www.healthqualityalliance.org/>

[27] Public reports are available on their Web sites: Maine: http://www.mhmc.info/; Minnesota: http://www.mncm.org/site/;Wisconsin: http://www.wchq.org/

[28] Puget Sound Community Checkup: A Recurring Report to the Community on Health Care Performance Across the Region. Puget Sound Health Alliance, July 2009. <http://www.wacommunitycheckup.org/?p=report_info>

[29] Better Health Great Cleveland. Community Health Checkup: Executive Summary, June 2009. <www.betterhealthcleveland.org.>

[30] See Consumers' CHECKBOOK Web site for more information: http://www.checkbook.org.

[31] The National Priorities Partnership is a collaborative effort of 28 organizations that have identified goals to focus performance improvement activities. www.nationalprioritiespartnership.org, accessed Sept 11, 2009.

[32] The list of activities profiled in this report is not exhaustive but instead designed to illustrate the many types of activities currently going on in the communities.

[33] Shaller, Dale. Consumer Engagement: Whose Responsibility is it? American Journal of Medical Quality 2007; 22: 309.

[34] Arnold, Sharon. Issue Brief: Improving Quality Health Care: The Role of Consumer Engagement. AcademyHealth/Robert Wood Johnson Foundation, October 2007. http://www.rwjf.org/files/research/ahbriefrwjfummary.pdf

[35] The Web site also includes performance measures for all of the hospitals in the state. Scanlon D, et al. Aligning Forces for Quality in Maine: A Community Snapshot. March 2009, Penn State University Center for Health Care and Policy Research.

[36] Ting HH, Shojania KG, Montori VM, Bradley EH. Quality Improvement: Science and Action. *Circulation* 2009;119:1962-1974.

[37] Shojania KG, McDonald KM, Wachter RM, Owens DK. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Agency for Healthcare Research and Quality Publication No. 04–0051–1; 2004. <http://www.ahrq.gov/downloads/pub/evidence/pdf/qualgap1/qualgap1.pdf.>

[38] Ting HH, Shojania KG, Montori VM, Bradley EH. Quality Improvement: Science and Action. *Circulation* 2009;119:1962-1974.

[39] *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.

[40] "A Breakthrough Series Collaborative is a short-term (6- to 15-month) learning system that brings together a large number of teams from hospitals or clinics to seek improvement in a focused topic area. Since 1995, IHI has sponsored over 50 such Collaborative projects on several dozen topics involving over 2,000 teams from 1,000 health care organizations. Collaboratives range in size from 12 to 160 organizational teams. Each team typically sends three of its members to attend Learning Sessions (three face-to-face meetings over the course of the Collaborative), with additional members working on improvements in the local organization." T*he Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.

[41] IPIP creates a system to assist primary care physicians and their practice teams to assess and improve the quality of chronic illness and preventive care. <http://www.ipip.us/>

[42] Institute for Healthcare Improvement, unpublished research. Cited from Rutherford P. *Transforming Care at the Bedside*, IHI Innovation Series 2004, page 2.

[43] Moy E, Dayton E, Clancy CM. Compiling The Evidence: The National Healthcare Disparities Reports. Health Affairs 2005; 24(2): 377-387.

[44] Smedley BD, Stith AY, Nelson AR; Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press; 2003.

[45] National Quality Forum. A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report. Washington, DC: NQF, 2009.

[46] Hasnain-Wynia R, Pierce D, Haque A, Hedges Greising C, Prince V, Reiter J. *Health Research and Educational Trust Disparities Toolkit.* 2007. <hretdisparities.org>

[47] For more information or to view the CLAS standards, see: <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

[48] IOM. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, 2009. <http://www.iom.edu/CMS/3809/61110/72796.aspx>

This report was prepared by Marsha Regenstein, Ph.D., M.C.P., research professor and Ellie Andres, M.P.H., research assistant with the Aligning Forces for Quality National Program Office, located at the Center for Health Care Quality in the George Washington University's Department of Health Policy.

Information about Aligning Forces communities and their efforts can be found at the program Web site, www.forces4quality.org and at http://www.rwjf.org/qualityequality/af4q/.

Robert Wood Johnson Foundation